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O TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9218  
CERTIFICATE OF DEATH  
09208

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Golt</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Golt</b> d. STREET ADDRESS <b>X</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>Allen</b> Last <b>Allen</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25 1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Masonry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lum Allen</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Rutter</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>221-05-2149</b>		17. INFORMANT <b>Elizabeth Allen</b>		Address <b>Golt Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> <b>420.1</b> DUE TO (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>degeneration of the heart muscle</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <b>3-4 yrs</b> <b>3-4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 6</b> , 19 <b>60</b> to <b>July 31</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>July 4</b> , 19 <b>61</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>G-EZA KORALEWSKI</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 2. 61</b>		22c. PHYSICIAN'S NAME (Type) <b>G-EZA KORALEWSKI</b>	
22d. ADDRESS <b>MILLINGTON MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dales Cemetery</b>		23d. LOCATION (City, town or county) <b>Middletown Del.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Pillow</b>				25a. REC'D BY REGISTRAR <b>Aug 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

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Received from [illegible] [illegible]

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9219

## CERTIFICATE OF DEATH

08209

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Kent</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golt</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golt</b>			
c. LENGTH OF STAY IN 1b <b>3yrs.</b>				d. STREET ADDRESS <b>X</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>George S. Beatty</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Aug. 22, 1961</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 17, 1870</b>	
<b>9. AGE</b> (In years last birthday) <b>91</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>George D. Beatty</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>No record Yarnall</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>---</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT</b> <b>George D. Beatty Golt Md.</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> DUE TO (c) <b>Chronic myocardial</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Smile</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19 20</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>Aug 1, 1961</b> , to <b>Aug 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 15, 1961</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>@ H. Metcalfe</b> M.D. <b>C. H. METCALFE</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Penikeseville Ind.</b>		22b. DATE SIGNED <b>8/23/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baptist Lower Maerion Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bryn Mawr Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward P. Mellington</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9220

09210

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington. Rural - HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millington. Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>U.</b> Last <b>Chance</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March, 17, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>	9. AGE (In years last birthday) <b>87</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel M. Chance</b>		14. MOTHER'S MAIDEN NAME <b>Mary Chance</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>None.</b>		17. INFORMANT <b>Dudley Chance, Rural Millington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 61</b> to <b>28 Aug 61</b> , that (I) (we) last saw the deceased alive on <b>28 Aug 61</b> , and that death occurred at <b>2p</b> M. from the causes and on the date stated above.		22a. SIGNATURE <b>Wallace Garner Obenshain</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Wallace Garner Obenshain, M.D.</b>	
22b. DATE <b>29 Aug 61</b>		22d. ADDRESS <b>Cecilton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 31, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Church Hill, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08211

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE B Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b short		d. STREET ADDRESS 6220 Brook Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Bay near Tolchester Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Michael Cyran		4. DATE OF DEATH Aug. 13, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1933
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vending Machine Co. Employee		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley J. Cyran		14. MOTHER'S MAIDEN NAME Annabelle (Last Name Not known)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 212305849	
17. INFORMANT Mrs. Carol Marie Cyran		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Drowning DUE TO Boating accident in Chesapeake Bay near Tolchester Beach (RFD Chestertown, Md.) Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) cause last.			
INTERVAL BETWEEN ONSET AND DEATH Short			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) boat sank	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) Kent Co. Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-18-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR ADDRESS 5305 Harford Rd.	
24b. REGISTRAR'S SIGNATURE		DATE AUG 18 '61	

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Residence		Occupation		Cause of Death		Place of Death	
Manner of Death		Medical History		Physical Examination		Autopsy	
Toxicology		Microscopic Examination		Bacteriology		Chemistry	
X-ray		Other		Remarks		Signature of Examiner	
Date of Report		Examiner's Name		Examiner's Title		Examiner's Address	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9222

## CERTIFICATE OF DEATH

Items 3 & 16 Film G294 9/13/61 iwr

09212

<b>1. PLACE OF DEATH</b> a. COUNTY <div style="text-align: center; font-size: 1.2em;">Kent</div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Chestertown</div> c. LENGTH OF STAY IN b. <div style="text-align: center; font-size: 1.2em;">2 hrs.</div> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">Kent &amp; Queen Anne's</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div> b. COUNTY <div style="text-align: center; font-size: 1.2em;">Kent</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Chestertown</div> d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">107 High Street</div>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-size: 1.2em;">Doe Dyer</div>		<b>4. DATE OF DEATH</b> Month Day Year <div style="text-align: center; font-size: 1.2em;">8 4 1961</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <div style="text-align: center; font-size: 1.2em;">Male</div>		<b>6. COLOR OR RACE</b> <div style="text-align: center; font-size: 1.2em;">White</div>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. BIRTH DATE</b> Month Day Year <div style="text-align: center; font-size: 1.2em;">6/12/84</div>		<b>9. AGE</b> (In years last birthday) <div style="text-align: center; font-size: 1.2em;">77 yrs.</div>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. 			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Supervisor Steam plant-Penna. Railroad</div>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center; font-size: 1.2em;">Railroad</div>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">Maryland</div>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center; font-size: 1.2em;">U.S.</div>			
<b>13. FATHER'S NAME</b> <div style="text-align: center; font-size: 1.2em;">David Doub</div>				<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center; font-size: 1.2em;">Alice Kenny</div>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center; font-size: 1.2em;">no</div>				<b>16. SOCIAL SECURITY NO.</b> <div style="text-align: center; font-size: 1.2em;">don't know</div>			
<b>17. INFORMANT</b> Address <div style="text-align: center; font-size: 1.2em;">Dover L. Doub (previous adm.)</div>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center; font-size: 1.5em;">420.1</div> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <div style="text-align: center; font-size: 1.5em;">Myocardial infarction -</div> (c) <div style="text-align: center; font-size: 1.5em;">Arterio sclerosis -</div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <div style="text-align: center; font-size: 1.5em;">Chronic pulmonary congestion</div>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <div style="text-align: center; font-size: 1.2em;">19</div>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> 		<b>20g. (County)</b> 		<b>20h. (State)</b> 			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <div style="text-align: center; font-size: 1.2em;">8-3</div> <b>1961, to</b> <div style="text-align: center; font-size: 1.2em;">8-4</div> <b>1961, that (I) (we) last saw the deceased alive on</b> <div style="text-align: center; font-size: 1.2em;">8-4</div> <b>1961, and that death occurred at</b> <div style="text-align: center; font-size: 1.2em;">P.M.</div> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <div style="text-align: center; font-size: 1.5em;">Harry Paul Ross</div>				<b>22b. DATE SIGNED</b> <div style="text-align: center; font-size: 1.2em;">8-5-61</div>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <div style="text-align: center; font-size: 1.2em;">HARRY PAUL ROSS</div>				<b>22d. ADDRESS</b> <div style="text-align: center; font-size: 1.2em;">203 N. Queen Chestertown, Md</div>			
<b>23a. BURIAL, CREMATION, REMAINS</b> (Type) <div style="text-align: center; font-size: 1.2em;">Burial</div>		<b>23b. DATE THEREOF</b> <div style="text-align: center; font-size: 1.2em;">8/8/61</div>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center; font-size: 1.2em;">Chester Cemetery</div>			
<b>23d. LOCATION</b> (City, town or county) <div style="text-align: center; font-size: 1.2em;">Chestertown, Md.</div>		<b>23e. (State)</b> 					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.5em;">J. Wells Wells</div>				<b>25a. REC'D BY REGISTRAR</b> DATE <div style="text-align: center; font-size: 1.2em;">AUG 8 '61</div>			
<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.2em;">Arthur S. Hanna</div>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

M

232

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G294 9/7/61 iwk

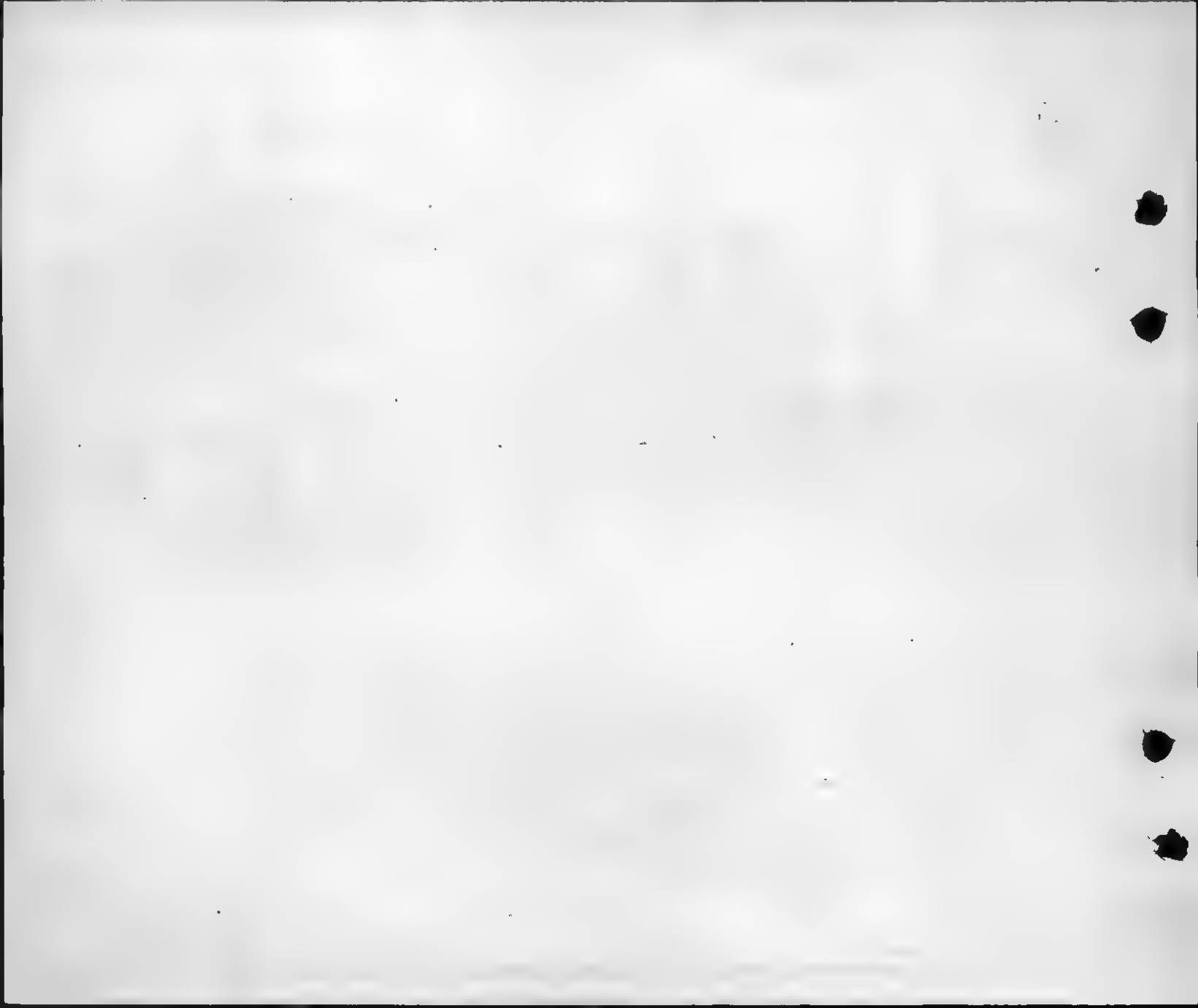
## CERTIFICATE OF DEATH

Reg. Dist. No. 09213

9223

1. PLACE OF DEATH a. COUNTY <b>KENT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETTERTON</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hotel Rigby</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>805 St. Paul Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle Last <b>FINCH</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1887</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Madison Apts.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Rowland Finch</b>		14. MOTHER'S MAIDEN NAME <b>Georgella Ramey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-34-3377</b>	
17. INFORMANT <b>A Mrs. Eleanor K. Finch</b>		Address <b>812 Beaumont Ave. 12</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Centricular Fibrillation</b> +33.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic auricular fibrillation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute pyelonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 14, 1961</b> to <b>August 15, 1961</b> that I last saw the deceased alive on <b>August 14, 1961</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>8-15-61</b>			
ACTUAL SIGNATURE <b>Florence Deringer Joyce</b>		PHYSICIAN'S NAME (Type) <b>FLORENCE DERINGER JOYCE WORTON, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/17/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Ave.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tichner &amp; Son</b>		ADDRESS <b>North &amp; Penn Ave Baltimore Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

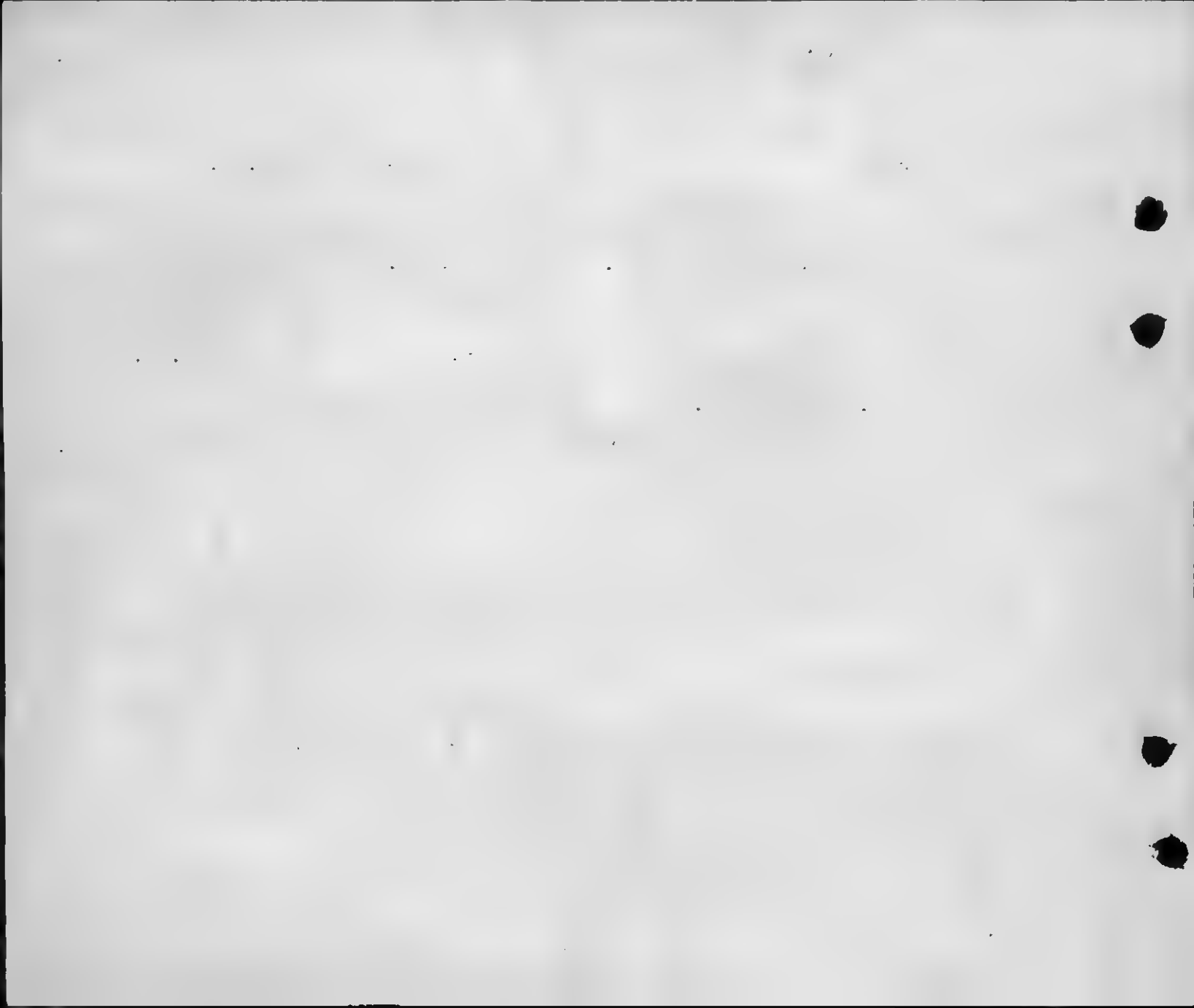
9224

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09214

1. PLACE OF DEATH a. COUNTY Kent, Chestertown, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, R. D.	
c. LENGTH OF STAY IN Ill four days		d. STREET ADDRESS 17X	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent and Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) Walter H. Hadaway, Jr.		4. DATE OF DEATH August 5 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter H. Hadaway, Sr.		14. MOTHER'S MAIDEN NAME Virginia Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO 220-34-9204	
17. INFORMATION Hospital Records - Chestertown, Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Tetanus DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO cause last, underlying cause last, (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/1/1961, to 8/5/1961, that (I) (we) last saw the deceased alive on 8/5/1961, and that death occurred at 8:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Solon		22b. DATE SIGNED 8/6/61	
22c. PHYSICIAN'S NAME (Type) THOMAS SOLON		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/8/61	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) Rock Hall, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		25a. REC'D BY REGISTRAR AUG 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			





TO HOSPITAL OR AT THE Dying Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

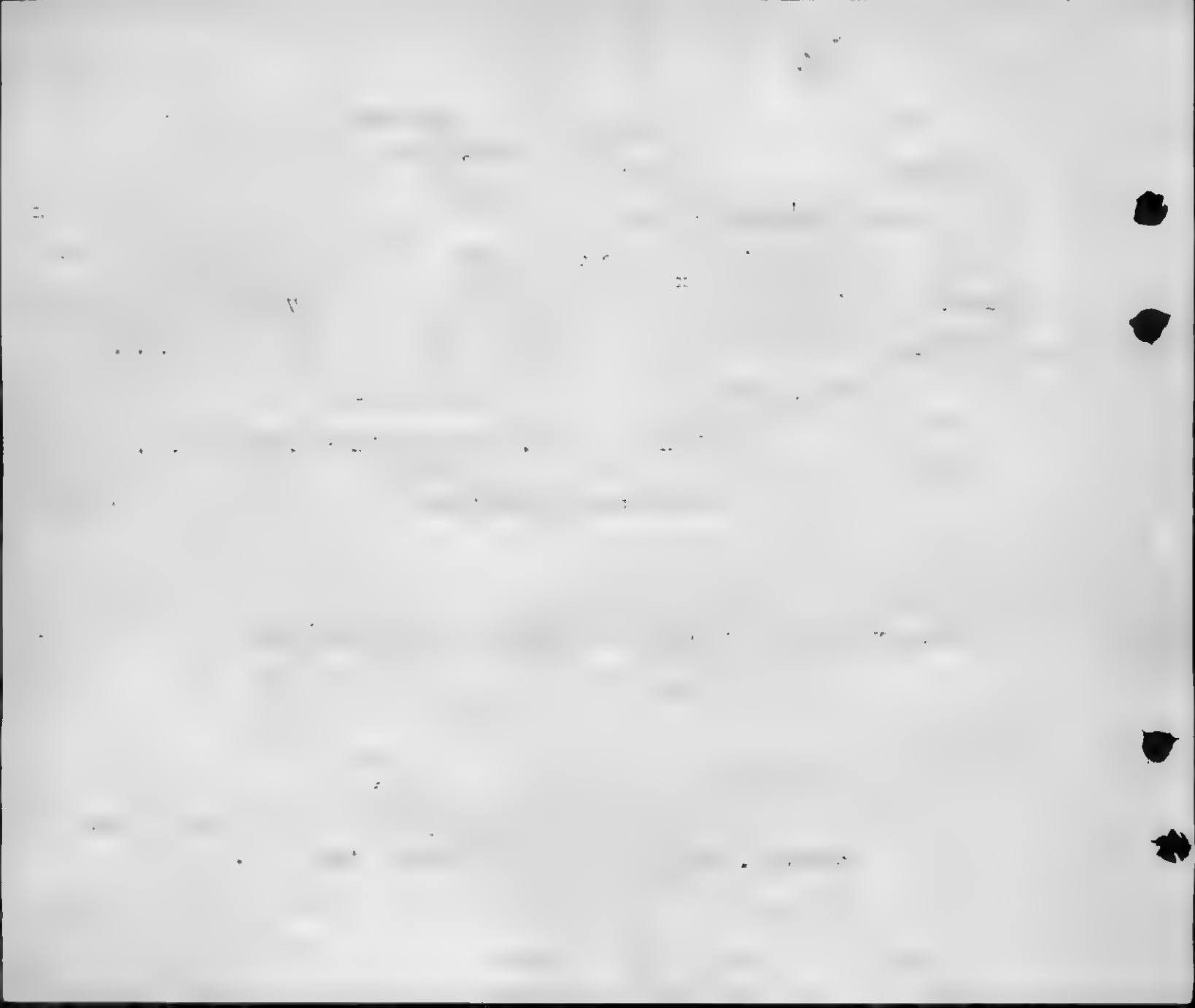
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07

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9225											
CERTIFICATE OF DEATH											
09215											
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY in lb. <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rock Hall (rural)</b> d. STREET ADDRESS <b>RFD#1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Frances</b> Last <b>Mercer</b>						4. DATE OF DEATH Month <b>8</b> Day <b>1</b> Year <b>1961</b>					
5. SEX <b>Female</b>						6. COLOR OR RACE <b>White</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>8/1/93</b>					
9. AGE (in years last birthday) <b>67</b> yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						11. BIRTHPLACE County & State, or foreign country <b>Maryland</b>					
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Thomas Poole</b>						14. MOTHER'S MAIDEN NAME <b>Barbara Zellers</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>213 14 1221</b>					
17. INFORMANT <b>Mrs. Catherine Williams, Rock Hall, Md. (daughter)</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary arteriosclerosis &amp; Congestive heart failure</b>											
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> ..... <b>1961</b> to <b>8/1</b> ..... <b>1961</b> that (I) (we) last saw the deceased alive on <b>8/1/61</b> ..... <b>19</b> .. and that death occurred <b>10</b> .. <b>A</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert W. Farr</b>											
22b. DATE SIGNED <b>Aug 1 1961</b>											
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>											
22d. ADDRESS <b>Chestertown Md.</b>											
23a. (BURIAL) CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE THEREOF <b>Aug 3-61</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>											
23d. LOCATION (City, town or county) (State) <b>Rock Hall Md</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest L. Lane</b>											
ADDRESS <b>Church Hill</b>											
25a. REC'D BY REGISTRAR <b>AUG 7 61</b>											
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>											



9225

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

92216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
c. LENGTH OF STAY IN TB Short		d. STREET ADDRESS 207 Queen St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Electric Sub Station (Rock Hall)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) C. Allie Myers		4. DATE OF DEATH Aug. 3, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1902
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Maintenance		11. BIRTHPLACE (State or foreign country) Kent CO. Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin Myers	
14. MOTHER'S MAIDEN NAME Mary Emma Brice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	
16. SOCIAL SECURITY NO. 096-09-9220		17. INFORMANT Mrs. Elise Myers Queen St. Chestertown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 914.3 DUE TO ELECTROCUTION Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH NONE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally touched 2400 volt line in Electric Substation	
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. AUG 3 1961	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sub-station	20f. CITY or town Rock Hall KENT MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE O.S. GULBRANDSEN M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aching	
EXAMINER'S NAME (Type) O.S. GULBRANDSEN M.D.		DATE SIGNED 8/3/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/5/61	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE AUG 7 '61	24b. REGISTRAR'S SIGNATURE A. J. S. Francis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the registrar prior to burial, cremation, or removal.



Reg. Dist. No. 119217

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/55

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock HALL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock HALL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>ROUSE</b> Last <b>ROUSE</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 3 - 1881</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>10WA</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUBEN ROUSE</b>		14. MOTHER'S MAIDEN NAME <b>ROSANNA GOODEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. F.R. KENT = Rock Hall MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>122.1</b> DUE TO (b) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Longstanding</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 25, 1961</b> to <b>Aug 6, 1961</b> , that I last saw the deceased alive on <b>Aug 5, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall MD</b> DATE SIGNED <b>MA</b>			
ACTUAL SIGNATURE <b>Robert C. Tiltsch</b> M.D.		PHYSICIAN'S NAME (Type) <b>ROBERT C. TILTSCH</b> <b>Rock Hall MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 9</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		24a. REC'D BY REGISTRAR <b>Church Hill Ind.</b>	
24b. REGISTRAR'S SIGNATURE <b>Aug 10 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Aug 10 '61</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

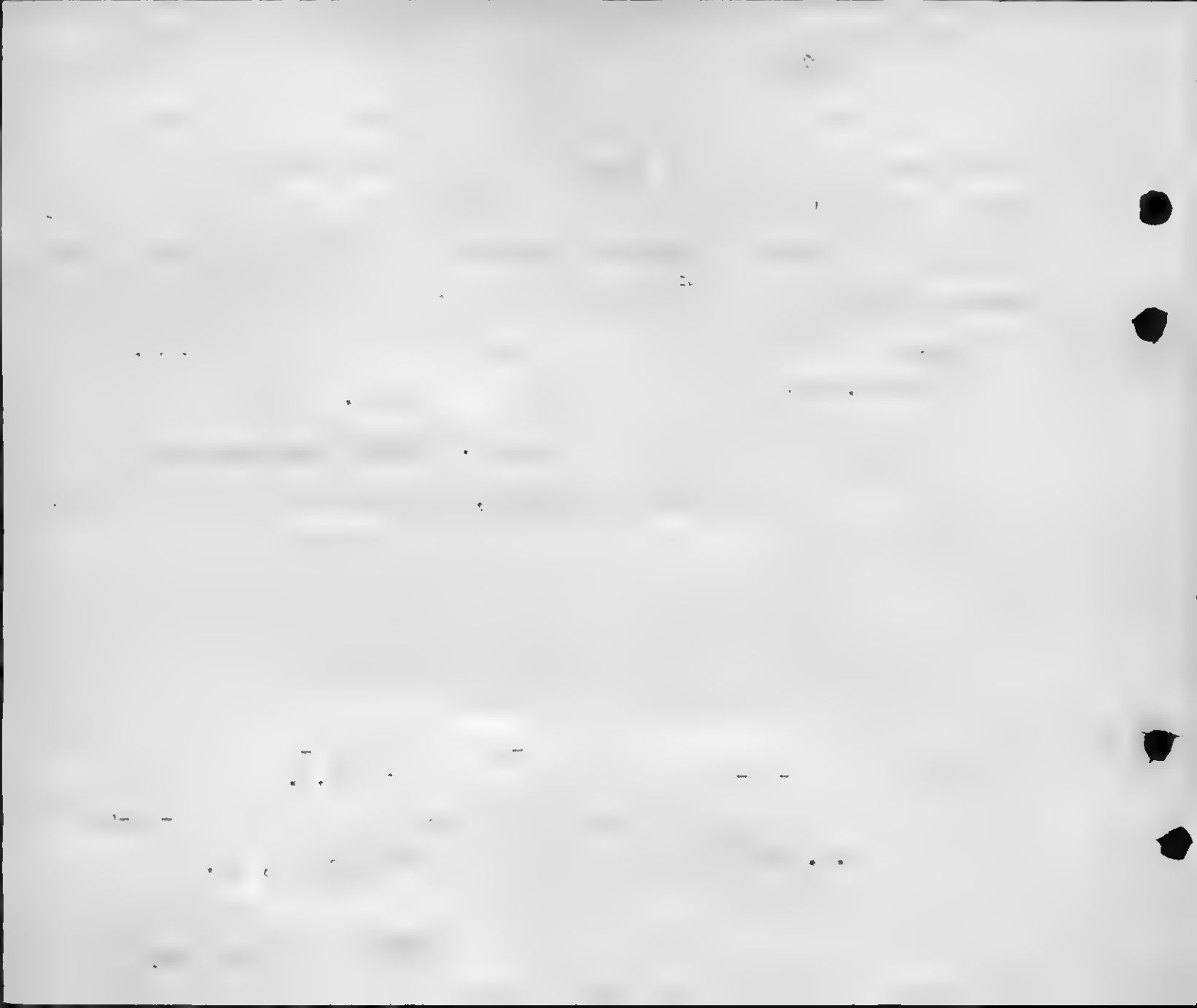
9228

## CERTIFICATE OF DEATH

09218

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN (b) <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (rural)</b> d. STREET ADDRESS <b>RFD#2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thelma Catherine Shinnamon</b>		<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>14</b> Year <b>1961</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.A.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Samuel J. Boyd</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Sara H. Scully</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Thelma C. Shinnamon (Hospital records)</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a).</b> <b>Pulmonary embolism, postoperative</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST.</b> <b>X</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>45 minutes</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>7-30</b> , <b>1961</b> <b>to</b> <b>8-14</b> , <b>1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>8-14-61</b> , <b>1961</b> , <b>and that death occurred at</b> <b>5:25 p.m.</b> , <b>causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>A.C. Dick</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Chestertown, Md.</b>		<b>22b. DATE SIGNED</b> <b>8-14-61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>B</b> <b>23b. DATE THEREOF</b> <b>8-17-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Elkridge</b> <b>23d. LOCATION (City, town or county)</b> <b>Elkridge, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>1681</b> <b>DATE</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>McElroy - 130 E. F...</b> <b>ADDRESS</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. H...</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9229 Item 9 File 9222 07/21/61 LWK

1. PLACE OF DEATH  
a. COUNTY **Kent**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Chestertown**  
c. LENGTH OF STAY IN b. **3 days**  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Kent & Queen Anne's Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland**  
b. COUNTY **Kent**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Rock Hall**  
d. STREET ADDRESS **1**

3. NAME OF DECEASED (Type or print)  
First **Mary** Middle **Pownall** Last **Tierney**

4. DATE OF DEATH  
Month **8** Day **26** Year **1961**

5. SEX **Female**  
6. COLOR OR RACE **White**  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH **9/9/07**  
9. AGE (In year last birthday) **53 5/4**  
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (Country & State, or foreign country) **Pennsylvania**  
12. CITIZEN OF WHAT COUNTRY **U.S.**

13. FATHER'S NAME **Vincent Pownall**  
14. MOTHER'S MAIDEN NAME **Bertha Walton**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no**  
16. SOCIAL SECURITY NO. **don't know**  
17. INFORMANT **James J. Tierney** Address **Rock Hall, Maryland**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Nutritional and probable electrolyte disturbance**  
DUE TO (b) **due to vomiting and refusal to eat**  
DUE TO (c) **Congestive failure**  
**Mitral regurgitant stenosis and insufficiency**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I  
INTERVAL BETWEEN ONSET AND DEATH **Several Weeks**  
**6 months**  
**Many Years**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ☐  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. **19**  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from... **8/23/61**, 19... to... **9/26/61**, 19... that (I) (we) last saw the deceased alive on **8/26/61**, 19... and that death occurred **10:25 AM** on the causes and on the date stated above.

22a. SIGNATURE **Robert W. Farr** M.D.  
22b. DATE SIGNED **8/27/61**  
22c. PHYSICIAN'S NAME (Type) **Robert W. Farr**  
22d. ADDRESS **Chestertown, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Cremation**  
23b. DATE THEREOF **8/28/61**  
23c. NAME OF CEMETERY OR CREMATORY **Silverbrook Crematory**  
23d. LOCATION (City, town or county) (State) **Wilmington, / Dela.**

24. FUNERAL DIRECTOR'S SIGNATURE **Willis Wells** ADDRESS **Chestertown, Md.**  
25a. RECEIVED BY REGISTRAR **29 '61**  
25b. REGISTRAR'S SIGNATURE **Arthur S. Kline**



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MEDICAL CERTIFICATION**

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
<b>CERTIFICATE OF DEATH</b> <span style="float: left;">Item 2 Film G293</span> <span style="float: right;">8/18/61 - ITEM #13 - SEE BIRTH CERTIFICATE</span>					
1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN lb <b>LIFETIME</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KENT &amp; QUEEN ANNE'S HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. NAME OF DECEASED (Type or print) <b>HARRY LEWIS WALLEY</b>		g. DATE OF DEATH <b>AUGUST 13 1961</b>			
h. SEX <b>MALE</b>		i. COLOR OR RACE <b>NEGRO</b>		j. MARIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
k. AGE (In years last birthday) <b>25</b>		l. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>		m. IF UNDER 24 HRS. Hours <b>2</b> Min <b>25</b>	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		o. KIND OF BUSINESS OR INDUSTRY <b>—</b>		p. BIRTHPLACE (County & State, or foreign country) <b>KENT - MARYLAND</b>	
q. CITIZEN OF WHAT COUNTRY? <b>U.S. BORN</b>					
r. FATHER'S NAME <b>LEWIS WILSON</b>			s. MOTHER'S MAIDEN NAME <b>MARY WALLEY</b>		
t. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		u. SOCIAL SECURITY NO. <b>NONE</b>		v. INFORMANT Address <b>HOSPITAL RECORDS CHESTERTOWN, MD</b>	
w. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>FETAL ATALECTASIS</b> Conditions, if any, which gave rise to immediate cause } (b) <b>PREMATURITY (22wks 1lb 3oz)</b> (a), stating the underlying cause last. } (c)					
x. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
y. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
z. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		aa. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
ab. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:00</b> p.m. <b>—</b>		ac. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		ad. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
ae. (City or town) (County) (State)					
af. I certify that (I) (this hospital) attended the deceased from <b>AUG 13, 1961</b> to <b>AUG 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>AUG 13, 1961</b> , and that death occurred at <b>6:15 AM</b> , from the causes and on the date stated above.					
ag. SIGNATURE <b>O. S. GULBRANDSEN, MD</b>		ah. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		ai. DATE SIGNED <b>8-13-61</b>	
aj. PHYSICIAN'S NAME (Type) <b>O. S. GULBRANDSEN, MD</b>		ak. ADDRESS <b>CHESTERTOWN, MD.</b>			
al. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		am. DATE THEREOF <b>8-14-61</b>		an. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMT</b>	
ao. LOCATION (City, town or county) (State) <b>STILL POND, MD.</b>					
ap. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		aq. ADDRESS <b>STILL POND, MD.</b>		ar. REC'D BY REGISTRAR <b>AUG 15 '61</b>	
as. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>					

0890

(M)

(C)

(J)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9231

09224

<b>1. PLACE OF DEATH</b> a. COUNTY <u>KENT</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u> <u>37</u>		d. STREET ADDRESS <u>212 COURT ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENT &amp; GREEN ANNE'S GEN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DONNA LYNN WILSON</u>		4. DATE OF DEATH <u>AUG. 21 1961</u>		5. SEX <u>Fe.</u> 6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>AUG. 19, 1961</u>		9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>34</u>		IF UNDER 24 HRS. Hours <u>42</u> Min. <u>42</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AM.</u>				13. FATHER'S NAME <u>JESSIE - WILSON JR.</u>			
14. MOTHER'S MAIDEN NAME <u>NORMA JEAN BLACK</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>HOSPITAL RECORDS</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Foetal Atelectasis</u> <u>762.5</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>15</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19-61</u> <u>8:20 PM</u> to <u>8-21-61</u> <u>6 AM</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry Paul Ross</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>				22d. ADDRESS <u>203 N. Queen ST Chestertown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MORNEC CEM.</u>		23d. LOCATION (City, town or county) (State) <u>near Chestertown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bennett W. Wadley</u>				25a. REC'D BY REGISTRAR <u>AUG 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

(M)

(U)

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